S.3627, THE HIV/AIDS SAVE LIVES FIRST ACT OF 2010

The President's Emergency Plan for AIDS Relief—known as PEPFAR—has been wildly successful and has begun to reverse the course of the AIDS epidemic worldwide. Two and half million HIV/AIDS patients from 30 different countries currently have access to lifesaving treatment because of PEPFAR. A 2009 report found that from 2004-2007 as many as 1.2 million lives had been saved because of the program.[1]

In 2008, Congress and the President in an overwhelmingly bipartisan fashion passed the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 to continue the important life-saving work of the PEPFAR program.

It is of grave concern, then, that our fight against AIDS **is now at risk of failure**. A recent New York Times article, "At Front Lines, AIDS War Is Falling Apart," details how hundreds of thousands of patients are being denied promised care in countries such as Uganda—a country once held up as PEPFAR's success story. Government officials have confirmed the rationing of treatment slots and have advised their partners to support "an equitable system of triage for total ART [antiretroviral drug treatment] slots…."

Former UNAIDS chief Dr. Piot remarked about past success and doubts about the future: "Then, we were at a tipping point in the right direction," he explained. "Now I'm afraid we're at a tipping point in the wrong direction."

We must not lose sight of the fact that HIV/AIDS is a disease that we can diagnose, treat, and prevent. Not only does treatment save lives—it is the best prevention tool we have. Treatment lowers viral loads, which reduces the likelihood of individuals spreading the disease by as much as 92 percent.[2] Treatment reduces transmission among partners, eliminates baby AIDS, and keeps those with HIV in the medical system where they can receive proper counseling and care. And the availability of treatment is integral to promoting HIV/AIDS testing and early diagnosis.

To accomplish the important goal of ensuring life-saving medical treatment to as many patients as possible, we have introduced **S.XXXX, The HIV/AIDS Save Lives First Act of 2010:**

LIFE-SAVING TREATMENT: THE #1 PRIORITY

If you ask Africans what PEPFAR is, they will tell you it is about AIDS treatment. It is the treatment component of PEPFAR that has made it the most successful U.S. humanitarian effort in history because it has literally saved the lives of millions, preserved families and communities, and rescued countless babies from being born with an AIDS death sentence.

The PEPFAR program's long-term success relies on the promise of life-saving medical treatment to those in need. Unfortunately, according to a recent report the recent moratorium on new enrollees in the program has already caused an estimated **3,000 deaths**.[3]

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[1] Stephen Dinan, "Bush AIDS fight saved 1.1M, study says," The Washington Times, April 7, 2009, http://www.washingtontimes.com/news/2009/apr/07/bush-aids-fight-saved-11-million-study-says/ (July 13, 2010).

[2] Donnell, D et al "Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis," May 27, 2010, The Lancet, DOI:10.1016/S0140-6736(10)60705-2, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960705-2/abstract (July 15, 2010).

[3] Girard et al., "Universal Access in the Fight Against HIV/AIDS," Science Magazine, July 9, 2010, pg. 147-149, http://www.sciencemag.org/cgi/content/full/329/5988/147 (July 14, 2010).

The HIV/AIDS Save Lives First Act strengthens the current policy that requires a majority of all funding under PEPFAR be spent on life-saving HIV/AIDS treatment. Specifically, this legislation would increase the treatment allocation to 75 percent of all PEPFAR funding. It also sets the modest goal that by 2013 we treat 5 million people for HIV/AIDS.

Many claim that we cannot treat our way out of this epidemic, but they ignore the simple truth that **treatment *is* prevention**. Analysts from the World Health Organization published research arguing we can drastically reduce the transmission of AIDS and virtually halt the widening epidemic in Africa within a *decade* through aggressive routine testing and early treatment.[4]

Other prevention efforts remain an important component of the program. Without the reliable promise of access to treatment, however, the PEPFAR program will not enjoy long-term success. This legislation ensures that the PEPFAR program fulfills its promises, saves the most lives possible, and reduces transmission of the disease.

The HIV/AIDS Save Lives First Act also allocates a small percentage of funding for the critical diagnostic screening that must be ramped up dramatically if we are to locate and treat every infected person in the countries where PEPFAR operates. Finally, the bill acknowledges that every baby infected with HIV by her mother during birth or breastfeeding is a largely preventable tragedy. The bill would target baby AIDS for complete elimination with 100% coverage with the medical protocols that prevent almost all instances of mother-to-child HIV transmission.

SAVE AS MANY LIVES AS POSSIBLE: REQUIRE MORE EFFICIENCY

The Save Lives First Act requires recipients of funding to spend no more than $500 in annual PEPFAR funding per patient they treat. As recently as 2008, documents provided by the administration show that the PEPFAR program spent $1,100 in annual treatment costs per patient. This is unacceptable—inefficiencies come at the cost of human lives by limiting the number of patients PEPFAR can treat.

The most commonly prescribed drug regimen costs just **$64 per year** and many organizations are providing care to patients for no more than **$250 per year**.[5] For example, Doctors Without Borders has had remarkable success in achieving treatment efficiencies and now reports that its per-patient treatment costs in Malawi were only $237 per year.[6]

While costs may vary from country to country—and patient to patient—it is both reasonable and important that every funding recipient under PEPFAR limit their aggregate per patient expenditures to $500 per patient. The costs of drug regimens continue to fall dramatically, and PEPFAR must take advantage by providing treatment to more individuals.

The HIV/AIDS Save Lives First Act would require that any funding recipient under PEPFAR be limited to a treatment allocation of $500 per patient treated. This act would also set the modest goal that PEPFAR would treat 5 million patients by 2013. If the program's per patient expenditures were down to

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[4] Editorial, "A Breath-taking Aspiration for AIDS," the New York Times, December 1, 2008, http://www.nytimes.com/2008/12/01/opinion/01mon3.html?_r=1&th&emc=th (July 14, 2010).

[5] Aledort JE, Stearns BK et al. Primary Estimates of the Costs of ART Care at Five AIDS Healthcare Foundation Clinics in Sub-Saharan Africa. Rand Coporation, 2006.

[6] Memorandum from the Global AIDS Roundtable Treatment Working Group to the Office of the Global AIDS Coordinator, "Recommendation for US Treatment Target," October 15, 2009.

$500 per patient, the program should actually treating 6 million patients by 2013, and if everyone were as cost-effective as Doctors Without Borders we could be treating 10 million patients.[7]

In the rare instance of a country in which per patient expenditures remain above $500 per patient, it is more than reasonable to assume that these more developed countries have the resources—along with other global partners—to ensure that the per patient treatment expenditures ensure access to the highest-quality treatment for each patient.

ENSURE MONEY GOES TO PATIENTS: REDUCE OVERHEAD

Everyone can agree that dollars provided to HIV/AIDS treatment should go directly to patient care—not bloated administrative budgets. A common way of protecting this important principle is to limit the administrative budget for PEPFAR funding recipients.

The HIV/AIDS Save Lives First Act limits administrative overhead to 10 percent of total expenditures for every funding recipient under the program. The bill also limits the State Department's administrative budget for PEPFAR to 10 percent of total funding.

THE FIRST STEP: KNOW YOUR STATUS

Again, treatment *is* prevention. But this strategy relies on identifying HIV positive individuals who are unaware of their status and linking them to treatment and counseling. The first step to any prevention strategy is an aggressive testing strategy. Unfortunately, only about **40 percent** of people with HIV in developing countries are aware of their status.[8]

The HIV/AIDS Save Lives First Act sets aside 5 percent of PEPFAR funding to dramatically ramp up rapid HIV diagnosis to identify people who do not yet know their HIV status in order to get people in to treatment and early reduce their transmission rates through treatment and education.

This bill also sets a target of conducting 1 billion rapid tests by 2013 and sets aside 25% of testing money to help countries implement a policy of universal, opt-out rapid HIV testing.

ENOUGH IS ENOUGH: ENDING BABY AIDS ONCE AND FOR ALL

Rapid testing and access to treatment are particularly important to end baby AIDS (babies being born infected with HIV or becoming infected during their first year through breastfeeding) **once and for all**.

An estimated 430,000 children were born in 2008 newly infected with HIV, mainly through mother to child transmission. About **90 percent** of these infections occurred in Africa. Only 28 percent of pregnant women in Sub-Saharan Africa received an HIV test in 2008.[9] Moreover, the World Health Organization reports that access to AIDS drugs is severely limited in developing countries, with fewer than 10 percent of pregnant women with HIV in those countries having access to medication for their own health.[10]

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[7] Memorandum from the Global AIDS Roundtable Treatment Working Group to the Office of the Global AIDS Coordinator, "Recommendation for US Treatment Target," October 15, 2009.
[8] "2009 AIDS Epidemic Update," UNAIDS, November 2009, http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf (July 14, 2010).
[9] Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector. WHO, 2009.
[10] WHO/UNAIDS. Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector Progress Report, April 2007

Of course, dramatic gains are seen when universal testing of pregnant women and newborns is provided along with appropriate prophylaxis of infections that are that are identified through testing. In the United States, new cases of baby AIDS have been virtually eliminated. Studies have found that 99 percent of babies were born uninfected if an infected mother was diagnosed and proper treatment was administered.[11]

Botswana, a country that used to have HIV infection rates as high as 50 percent of child-bearing-aged women, instituted these interventions. **Ninety-two percent** of pregnant women in the country are now being tested and the drop in HIV-positive mothers delivering infected babies dropped from 35% to 4% from 2004-2007, with 13,000 HIV-infected moms being identified annually.[12]

Prevention of mother-to-child-transmission (PMTCT) is cheap per life saved: as of 2008, estimated costs of PMTCT drugs to prevent the spread of HIV for (1) mother/child pair was US$167 (generics) and US$318 (branded), and the price of drugs and treatment have only declined since.[13]

The HIV/AIDS Save Lives First Act sets a target of eliminating baby AIDS in all PEPFAR countries by 2013, and sets out expectations for how to work towards that target by screening 100% of pregnant women and newborns in PEPFAR countries and providing prophylactic or ARV treatment for all HIV-positive moms or babies.

[11] Townsend et al, "Low rates of mother-to-child transmission of HIV following effective pregnancy interventions in the United Kingdom and Ireland, 2000-2006," AIDS, 22(8):973-981, May 11, 2008.
[12] PEPFAR Annual 2008 Report, "The Power of Partnerships", p. 12
[13] WHO/ AIDS Medicines Diagnostics Service (AMDS), PMTCT Forecasting Template.